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1. DEFINITIONS

1.1. **Action** in the context of PIHP services means

1.1.1. the denial or limited authorization of a requested service, including the type or level of service;

1.1.2. the reduction, suspension, or termination of a previously authorized service;

1.1.3. the denial in whole or in part, of payment for a service;

1.1.4. the failure to provide services in a timely manner, as defined by the state;

1.1.5. the failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b) or;

1.1.6. for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b)(2)(ii), to obtain services outside the network.

1.2. **Administrative Cost** means costs for the general operation of the public mental health system. These activities can not be identified with a specific direct or direct services support function.

1.3. **Annual Revenue** means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

1.4. **Appeal** means a request for review of an action as "action" is defined above.

1.5. **Capitation Payment** means a payment the Department of Social and Health Services (DSHS) makes periodically to a PIHP on behalf of each recipient enrolled under a contract for the provision of medical services under the State Medicaid Plan. MHD makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

1.6. **Central Contract Services ("CCS")** means the Department of Social and Health Services (DSHS) office of Central Contract Services.

1.7. **CFR** means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

1.8. **Children's Long Term Inpatient Programs ("CLIP")** means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in the Children's Long Term Inpatient Programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center)

1.9. **Community Mental Health Agency ("CHMA")** means Community Mental Health Agency that are subcontracted by the RSN and licensed by the State of Washington to provide mental health services covered under this Agreement.

1.10. **Community Support Services** means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for mentally ill persons being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for acutely mentally ill and severely emotionally disturbed children discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by regional support networks.

1.11. **Consumer** means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

1.12. **Contractor** means the Contractor, its employees, agents and subcontractors

1.13. **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

1.14. **Early Periodic Screening Diagnosis and Treatment ("EPSDT")** means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as amended.

1.15. **Emergent Care** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

1.16. **Emerging Best Practice or Promising Practice** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

1.17. **Enrollee** means a Medicaid recipient who is currently enrolled in a PIHP.

1.18. **Evidence Based Practice** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

1.19. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

1.20. **Family** means those the consumer defines as family or those appointed/assigned (e.g. parents, foster parents, guardians, siblings, caregivers, and significant others).

1.21. **Grievance** means the overall system that includes processes for grievance and appeals handled at the RSN level and access to the State fair hearing process.

1.22. **Large Rural Area** means areas with a population density of less than 20 people per square miles.

1.23.

1.24. **Medicaid Funds** means funds provided by CMS Authority under the Title XIX program.

1.25. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

1.26. **Mental Health Care Provider ("MHCP")** means the individual with primary responsibility for implementing an individualized service plan for mental health rehabilitation services.

1.27. **Mental Health Division ("MHD")** means the Mental Health Division of the Washington State Department of Social and Health Services ("DSHS"). DSHS has designated the Mental Health Division as the state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

1.28. **Mental Health Professional** means;

1.28.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

1.28.2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or

emotional disturbance, such experience gained under the supervision of a mental health professional;

1.28.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

1.28.4. A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

1.28.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

1.29. **Operating Reserve** means funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN/PIHP governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.

1.30. **Quality Assurance** means a focus on compliance to minimum requirements (e.g. rules, regulations, and contract terms) as well as reasonably expected levels of performance, quality, and practice.

1.31. **Quality Improvement** means a focus on activities to improve performance above minimum standards/ reasonably expected levels of performance, quality, and practice.

1.32. **Quality Strategy** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations

1.33. **Recovery** means the process in which people is able to live, work, learn, and participate fully in their communities.

1.34. **Regional Support Network ("RSN")** means a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region.

1.35. **Resilience** means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

1.36. **Revised Code of Washington ("RCW")** means the Revised Code of Washington. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

1.37. **Risk Reserve** means funds designated into a risk reserve account by official action of the RSN's governing body. Risk reserve funds may only be used in the event costs of providing service exceed the revenue the RSN receives.

1.38. **Routine Care** means a setting where evaluation and mental health services are provided to consumers on a regular basis. These services are intended to stabilized, sustain, and facilitate consumer recovery within his or her living situation and they do not meet the definition of urgent or emergent care.

1.39. **Routine Services** means non-emergent and non-urgent services are offered within fourteen (14) calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health.

1.40. **Rural Area** means areas with a population density of at least 20 and less than 500 people per square mile

1.41. **Service Areas** means the geographic area described in the section titled Service Areas for which the Contractor is responsible.

1.42. **Severely Emotional Disturbed Child** means a child who has been determined by the regional support network to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:
(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;
(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;
(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protective/welfare, special education, or developmental disabilities;
(d) Is at risk of escalating maladjustment due to:
(i) Chronic family dysfunction involving a mentally ill or inadequate caretaker;
(ii) Changes in custodial adults;
(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;
(iv) Subject to repeated physical abuse or neglect;
(v) Drug or alcohol abuse; or,
(vi) Homelessness.

1.43. **Subcontract** means a separate contract between the RSN and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations which the RSN is obligated to perform pursuant to this Agreement.

1.44. **Unobligated Mental Health Fund Balance** Funds designated from mental health revenue sources that have not been spent in the fiscal period they were received. These funds have not been set aside into a specific reserve account by official

action of the RSN's governing body, but they may be identified by the RSN for a specific use.

1.45. **Urban Area** means areas that have a population density of at least 500 people square mile.

1.46. **Washington Administrative Code ("WAC")** means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.

2. ENROLLMENT

2.1. The following enrollees who reside within the Contractor's service area are eligible for medically necessary mental health services provided under this contract:

2.1.1. Persons of all ages enrolled in any of the following programs or members of any of the following groups.

2.1.1.1. Children and Related Poverty Level Populations (TANF/AFDC);

2.1.1.2. Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) *except for those women who have a pregnancy-only Medicaid coupon;*

2.1.1.3. Blind/Disabled Children or Adults and Related Populations (who qualify for SSI);

2.1.1.4. Aged and Related Populations;

2.1.1.5. Foster Care Children;

2.1.1.6. Title XXI SCHIP Children, targeted low income children who are eligible to participate in Medicaid;

2.1.1.7. Individuals with serious and persistent mental illness; and

2.1.1.8. Enrolled children with "D" coupons or other evidence of placement by DSHS, who currently reside in the Contractor's service area without regard to the child's original residence.

3. INFORMATION REQUIREMENTS

3.1. **Information Requirements:** The Contractor shall ensure all enrollee information complies with the requirements of 42 CFR §438.100, §438.6(i)(3), and WAC 388-865-0410.

3.1.1. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall:

3.1.1.1. Provide to MHD the information necessary to update the Benefits Booklet for Medicaid Enrollees. The booklet is the mechanism by which enrollees are notified of their benefits, rights, and responsibilities; and

3.1.1.2. Provide a copy of the Benefits Booklet provided by MHD to any enrollee receiving services from the RSN and upon request at any time. The booklet can be downloaded from: http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml.

3.1.2. The Contactor shall assure that interpreter services are provided for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance or appeal.

3.1.3. The Contractor shall provide all written information and post client rights in the following languages: Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese. Information on how to access written materials must be provided prior to conducting an intake evaluation.

3.1.4. The Contractor shall provide information that clearly explains to enrollees how the enrollee can request and be provided written materials in alternate formats. Information explaining to the enrollee how to access these materials must be provided prior to an intake evaluation in an easily understood format.

3.1.5. Upon an enrollee's request, the Contractor shall provide:

3.1.5.1. Identification of individual Mental Health Care Providers (MHCP) who are not accepting new enrollees;

3.1.5.2. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

3.1.5.3. Information that includes but is not limited to, education, licensure, and Board certification and/or re-certification of mental health professionals and MHCPs.

3.1.6. The Contractor shall not refer a Healthy Options enrollee to the enrollee's Healthy Options managed care plan if the enrollee is determined to be eligible for services under this Agreement from the Contractor based on medical necessity and the Access to Care Standards.

3.2. **Customer Services**

3.2.1. The Contractor shall provide Customer Services that are customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders.

3.2.2. Customer Services staff shall:

3.2.2.1. Answer consumer service lines via both local and toll free numbers to respond to inquiries and complaints from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded;

3.2.2.2. Respond to inquiries or complaints and assist consumers, family members and stakeholders in a manner that resolves their inquiry, including the ability to respond to those with limited English proficiency or the hearing impaired.

3.2.3. The Contractor shall train Customer Services staff to distinguish between a complaint, Third Party Insurance issue, appeal or grievances and how to triage these to the appropriate party. Logs shall be kept that at a minimum to track:

3.2.3.1. The date of initial call, type of call, and resolution date;

3.2.3.2. The volume of calls and call responsiveness statistics on the consumer service line; and

3.2.3.3. The number of calls by category, average days to resolution, and percent of complaints resolved within 30 days.

4. PAYMENT

4.1. Contractor shall ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system.

4.2. Rates of Payment:

Eligible Rates	FY07 (September ’06-June ’07)
Non-Disabled Children	
Disabled Children	
Non-Disabled Adults	
Disabled Adults	

Additional federal Medicaid funds shall be paid to the Contractor based on a PMPM rate of $ for FY2007 (September 2006 through June 2007) for disabled children and disabled adult enrollees. The required match for these funds shall be provided by the Contractor from local funds eligible for federal match.

Sources of revenue that are eligible to be used as federal match are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Funds used for federal match under this Agreement may not be used as match for any other federal program. It can be local funds that have not been previously matched with federal funds at any point. Local funds do not include donations.

Mental health capitation rates were developed using Evaluation and Treatment

(E&T), outpatient, residential, and professional encounter data collected from the Regional Support Networks (RSNs) by MHD; Medicaid eligibility records obtained from the Medical Assistance Administration (MAA); RSN-specific revenue and expense reports provided by MHD; community inpatient claim records from the State's Medicaid Management Information System (MMIS) system. The MMIS inpatient data for services incurred July 2003 to June 2004 and RSN encounter data for services incurred January 1, 2004 through December 31, 2004 formed the primary basis for the capitation rate development. Revenue and expense reports were used to validate the reasonableness of data sources and used to develop the administrative cost assumptions.

Critical steps in the rate development process included the following:

- Inpatient, residential and outpatient utilization was summarized by major service category separately by RSN, adult/child, and disabled/non-disabled status.
- Utilization date was limited to Title XIX services only.
- A Unit Cost Survey was completed by most mental health providers, which was used to construct outpatient unit costs.
- Cost models were constructed using the utilization data and assigning unit price estimates.
- Adjustments for claim lag, seasonality, and utilization and cost trends were analyzed and performed as necessary.
- Assumptions for administrative costs, including some direct support services, were developed as a percentage of projected capitation revenue and implemented proportionately across rate cells.

Final rates were set within the actuarially constructed ranges based on policy goals of MHD. The rates are pending CMS, Region X approval. The Contractor acknowledges that the Agreement may have to be amended to reflect any required changes.

4.3. During the term of this contract, capitation payments are made at the beginning of each month of service. The Contractor shall be responsible to provide all mental health services through the end of the month for which it has received a capitation payment.

4.4. Capitation payments are calculated based on the previous two month's Medicaid enrollee count. The information is compiled to fit the Mental Health Division's categories of eligibles, which are shown in the Rates section of the contract. Enrollees are assigned to the Community Support Office (CSO) at the time of eligibility, unless it is a statewide CSO, TANF reinstatement or other circumstances that prevent equitable distribution of enrollees. In these circumstances enrollees are distributed by the zip code on file at the time of the distribution.

Capitation Payments are entered into the accounting payment system the first working day of the month. Two types of capitation payments are made each month. These are the Initial Estimate, 6-month Reconciliation.

4.4.1. Initial Estimate:

Estimated Gross Medicaid Payment: The initial estimate payment uses Medicaid enrollee data from two months prior to the first day of a particular month and applies the corresponding rate to calculate a gross Medicaid payment estimate for that month.

4.4.2. If the Contractor elects to use the MMIS system for inpatient claim processing MHD or its designee will bill the Contractor on a monthly basis for claims paid on behalf of the RSN during the prior month.

4.4.3. 6-Month Reconciliation:

The 6-Month Reconciliation payment is an adjustment for Medicaid enrollees for a particular month of service. After six months, Medicaid enrollee counts are final. MHD pays for any increase in Medicaid enrollees or collects for any decrease in Medicaid enrollees. Reconciliation ends 6 months after the last month of the contract term.

4.4.4. Each capitation payment will be reduced by the amount paid by MHD on behalf of the Contractor for unpaid assessments, penalties, damages, and other payments pending a dispute resolution process. If the dispute is still pending June 1, 2007, MHD will withhold the amount in question from the final payment until the dispute is resolved.

4.5. MHD will withhold 50 percent of the final payment under this Contract until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

4.6. Payments to providers by the RSN shall be made on a timely basis, consistent with claims payment procedures described in 1902(a) (37) (A) of the Social Security Act and 42 C.F.R. 447.45.

4.7. Contractor shall reimburse the subcontracted CMHA network and any crisis service provider accessed by enrollees while the enrollee is out of the State within 60 calendar days.

4.8. If Federal Financial Participation (FFP) is recouped from the Contractor, the Contractor must reimburse the amount recouped to MHD within 30 days of notification by MHD.

5. **REPORTING AND DELIVERABLES:** The Contractor shall provide policies, procedures, plans, or reports to MHD in compliance with the timelines and/or formats

indicated. The RSN Administrator or designee must attest, based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of documents submitted to MHD.

5.1. **Advisory Board and Governing Body Membership**

5.1.1. The Contractor shall submit membership rosters of the Advisory Board showing compliance with WAC 388-865-0222 to the MHD within 60 days of the execution of this contract. Any change in membership must be reported within 30 days of the change.

5.1.2. The Contractor must establish a Governing Body responsible for oversight of the Regional Support Network. The Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests of a Governing Body member and best interests of the RSN and the consumers it serves. The Contractor must submit membership roster(s) and by-laws of the Governing Body demonstrating compliance. These must be submitted to MHD for review 60 days after execution of this agreement. The Governing Body by-laws must include:

5.1.2.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;

5.1.2.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and

5.1.2.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

5.2. The Contractor shall submit to the MHD for approval its Level of Care Guidelines that meet the requirements described in the Resource Management Section within 90 days of the execution of this Agreement. The Contractor's Guidelines must be submitted to the MHD for approval 60 days prior to implementation of any changes.

5.3. **Financial Reporting and Certification**: The following reports and certifications, in formats provided by MHD, must be submitted on a quarterly basis. Reports are due within 30 days of the quarter end (September, December, March, and June of each year). The MHD reserves the right to require more frequent submission of the Revenue and Expenditure report.

5.3.1. PIHP Revenue, Expenditure, and Fund Balance report in compliance with the provisions in the Revenue and Expenditure Report Instructions for Mental Health Services.

5.3.2. The amounts paid to FQHCs for services must be reported and submitted as separate additional information to the Revenue and Expenditure reports.

5.3.3. Certifications that a process is in place for subcontractors to identify, pursue, and record all Third Party Resources.

5.3.4. Certification that administrative costs, as defined in the Revenue and Expenditure Report Instructions for Mental Health Services, incurred by the Contractor are no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by MHD.

5.3.5. Certification of the amount of local funds to be used for additional federal match.

5.3.6. If the Contractor is unable to certify the validity of the certifications or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS may initiate remedial action.

6.3.7 The Contractor shall report the level of PIHP unobligated mental health fund balance to MHD according to the Revenue and Expenditure Report Instructions for Mental Health Services .6.3.8 MHD reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. MHD agrees to involve the RSN in the decision process prior to implementing changes in format, and will request the RSN to review and comment on format changes before they go into effect whenever possible.

6. ACCESS AND CAPACITY

6.1. Network Capacity

6.1.1. The Contractor shall ensure sufficient capacity, including the number, mix, and geographic distribution of Community Mental Health Agencies (CMHA), and Mental Health Care Providers (MHCPs), is available to meet the needs of the anticipated number of enrollees in the service area. At a minimum the Contractor shall provide:

6.1.1.1. Access to an intake evaluation by a MHP;

6.1.1.2. Age-appropriate medically necessary mental health services as identified in the Medicaid state plan and the 1915(b) Medicaid Waiver; and

6.1.1.3. A geographic distribution and mix of agencies and providers that meet the access and travel standards described the Distance Standards.

6.1.2. The Contractor shall notify MHD in writing of any change in capacity that results in the Contractor being unable to meet any of the Access Standards as required in this agreement. Events that may affect capacity include; loss of a CMHA, decrease in the number or frequency of a required service, or any changes that result in the Contractor being unable to provide medically necessary services. MHD must approve any change that results in reduced capacity for more than 30 days.

6.2. **Access Standards** The Contractor shall make available crisis mental health services and medically necessary mental health services on a 24-hour, 7 days per week basis

6.2.1. Service Requests: A request for mental health services is defined as a point in time in which mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.

6.2.1.1. An intake evaluation must be initiated within 10 working days of the request for mental health services.

6.2.1.2. Emergent mental health care must occur within 2 hours of a request for mental health services from any source;

6.2.1.3. Urgent care must occur within 24 hours of a request for mental health services from any source; and

6.2.1.3.1. Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.

6.2.1.4. Routine mental health services must be offered to occur within 14 calendar days of a decision to authorize ongoing mental health services. The time from request for mental health services to first routine appointment must not exceed 28 calendar days unless the Contractor documents a reason for the delay.

6.2.2. **Authorization**:

6.2.2.1. The Contractors determination of eligibility for a intake evaluation shall be based on Medicaid eligibility and the existence of a current intake that establishes medical necessity.

6.2.2.2. The Contractors determination of eligibility for authorization of service shall be based on medical necessity and the Access to Care Standards following an intake evaluation.

6.2.2.3. A decision to authorize ongoing mental health services must occur within 14 calendar days from the date of request for mental health services unless the enrollee or the CMHA request an extension from the PIHP. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the enrollee or the CMHA. The Contractor must have a written policy and procedure to ensure consistent application of requests within the service area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.

6.2.2.4. The Contractor or its formal designee shall notify enrollees of authorization decisions within 14 working days of the decision through oral or written communication. A decision to deny authorization must be provided with a written Notice of Action to the enrollee.

6.2.2.5. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or described in the individual service plan must be determined by a Mental Health Professional with the appropriate clinical expertise to make that decision.

6.2.2.6. If the Contractor or its formal designee: a) denies a service authorization request; or b) authorizes a service in an amount, duration, or scope that is less than requested, the Contractor shall notify the requesting CMHA and the enrollee in writing within 14 working days of the decision.

6.2.3. **Distance Standards**

6.2.3.1. The Contractor shall ensure that when enrollees must travel to service sites, the sites are accessible as follows:

6.2.3.1.1. In Rural Areas, a 30-minute drive from the primary residence of the enrollee to the service site;

6.2.3.1.2. In Large Rural Geographic Areas, a 90-minute drive from the primary residence of the enrollee to the service site; and

6.2.3.1.3. In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90-minutes each way.

6.2.3.2. Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) to psychiatric inpatient services; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

7. QUALITY OF CARE

7.1. The Contractor shall participate with DSHS in the implementation, update, and evaluation of the Quality Strategy, located on the DSHS website.

7.2. The Contractor shall use its collected data, monitoring results, and services verification to review its ongoing quality management program. The Contractor shall engage in ongoing assessment and improvement of the quality of public mental health services in its service area, as well as evaluate the effectiveness of the overall regional system of care. At a minimum the Contractor shall:

7.2.1. Assess the degree to which mental health services and planning is driven by and incorporates enrollee and family voice;

7.2.2. Assess the degree to which mental health services are age, culturally and linguistically competent;

7.2.3. Assess the degree to which mental health services are provided in the least restrictive environment;

7.2.4. Assess the degree to which provided mental health services assist enrollees' progress toward recovery and resiliency; and

7.2.5. Assess the continuity in service and integration with other formal/informal systems and settings.

7.3. The Contractor shall ensure relevant results of grievances, fair hearings, reported sentinel incidents, appeals and actions are incorporated into system improvement.

7.4. The Contractor shall provide the interpretation of quality improvement feedback to CMHAs, the advisory board, and other interested parties.

7.5. The Contractor shall ensure that a group of enrollees and enrollees' families that are representative of the community being served, including all age groups, are invited to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented.

7.6. **Performance Indicators**

7.6.1. MHD will calculate and review the following indicators on a quarterly basis. If the Contractor does not meet MHD defined targets on any indicator, the Contractor must submit a formal Performance Improvement Project.

7.6.1.1. Medicaid Penetration Rate, (targets will be provided in the final contracts).

7.6.1.2. Time from the initiation of an intake evaluation to first non-crisis appointment shall not exceed 14 days.

7.6.1.3. State Hospital Bed Utilization shall not exceed the RSN allocation.

7.6.1.4. Outpatient Services must be provided within 7 days following a hospital discharge.

7.6.1.5. Telesage Outcome Assessment initiated at time of intake.

7.6.2. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

7.6.2.1. Provision of all necessary data;

7.6.2.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

7.6.2.3. Incorporation of the results into quality improvement activities.

7.7. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) surveys. The schedule will rotate annually between adults and youth/families. Participation must include at a minimum:

7.7.1. Provision of enrollee contact information to MHD;

7.7.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

7.7.3. Incorporation of results into PIHP specific quality improvement activities.

7.8. The Contractor shall attempt to initiate and complete a TeleSage outcome survey on every individual.

7.9. The Contractor must identify where improvement is needed and continue or implement at least four Performance Improvement Projects (PIP). At all times during the contract period this must include at least two clinical and two non-clinical projects. The PIPs can be a mix of PIPs identified by the MHD for statewide improvement and projects identified by the RSN for local improvements. The Contractor shall demonstrate sustained improvement over time.

7.10. The Contractor shall participate with MHD in review activities. Participation will include at a minimum:

7.10.1. The submission of requested materials necessary for a MHD initiated review within 30 days of the request;

7.10.2. The completion of site visit protocols provided by MHD; and

7.10.3. Assistance in scheduling interviews and agency visits required for the completion of the review.

7.11. **Quality Review Activities**

7.11.1. The Department of Social and Health Services (DSHS), Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:

7.11.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

7.11.1.2. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement; and

7.11.1.3. Audits and inspections of financial records.

7.11.2. The Contractor shall notify MHD when an entity other than DSHS performs any audit or review described above related to any activity contained in this Agreement.

7.11.3. At least annually the following required activities will be reviewed by DSHS, its agent, or an External Quality Review Organization:

7.11.3.1. Encounter Data Validation; and

7.11.3.2. Performance Improvement Projects.

7.11.4. The Contractor shall submit to an annual EQRO monitoring review. The monitoring review process uses standard methods and data collection tools and methods found in the CMS External Quality Review Protocols and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by the Contractor.

7.11.4.1. The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by DSHS or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, results are used to identify and correct problems and to improve care and services to enrollees.

7.11.4.2. DSHS will provide a copy of the EQRO Report to the Contractor, through print or electronic media and to interested parties such as enrollees, mental health advocacy groups, and members of the general public.

7.11.5. **Sentinel Incident Reporting**: The Contractor shall notify MHD of any sentinel incident as described below:

7.11.5.1. Examples of incidents to report include but are not limited to: homicide, attempted homicide, completed suicide, the unexpected death of a consumer, abuse or neglect of an enrollee by an employee or volunteer, loss of crisis lines, loss of service or residential sites.

7.11.5.2. Notification must be made to the Mental Health Services Chief or his/her designee during the business day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

7.11.5.3. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

7.11.5.4. When requested by MHD, a written report will be submitted within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7.12. **Practice Guidelines:** Practice Guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions.

7.12.1. The Contractor shall adopt and implement a minimum of two Practice Guidelines. The Contractor shall provide documentation describing the chosen guidelines to the MHD within 90 days of the execution of this Agreement. The Practice Guidelines must:

7.12.1.1. Be based on valid and reliable clinical evidence or a generally accepted among the mental health professionals in the community;

7.12.1.2. Consider the needs of the enrollees;

7.12.1.3. Be adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable;

7.12.1.4. Be disseminated to all affected providers and, upon request, to enrollees; and

7.12.1.5. Be chosen with regard to utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

8. SUBCONTRACTS

8.1. Provider Discrimination

8.1.1. The Contractor must ensure there is no discrimination with respect to: a) the participation, reimbursement, or indemnification of any CMHA that is acting within the scope of its license or certification under applicable State law solely upon the basis of that license or certification; and b) particular CMHAs who serve high risk mental health enrollees or specialize in mental health conditions that require costly treatment.

8.1.2. The Contractor must provide written notice to individual CMHAs or to groups of CMHAs as to the reason for the Contractor's decision if they are not selected for the Contractor's authorized network of providers.

8.1.3. All contracts with CMHAs must comply with 42 CFR §438.214.

8.2. Delegation

8.2.1. The Contractor must oversee, be accountable for, and monitor functions and responsibilities performed by or delegated to a subcontractor on an ongoing basis including the completion of an annual formal review.

8.2.2. Prior to any delegation of responsibility or authority to a subcontractor, the Contractor shall use a formal delegation plan, consistent with the requirements of 42 CFR §438.230, to evaluate the subcontractors' ability to perform delegated activities. Within 90 days of execution of this Agreement the Contractor shall submit its delegation plan to the MHD for approval. The delegation plan must include the following:

8.2.2.1. An evaluation of the prospective subcontractor's ability to perform delegated activities;

8.2.2.2. A detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan;. and

8.2.2.3. A copy of the existing or draft subcontract that specifies the activities and report responsibilities delegated and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is not adequate.

8.2.2.4. The Care Management functions as described in this contract cannot be delegated to a subcontracted CMHA within the Contractor's service area.

8.2.3. No delegation or subcontract will terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor is fully responsible for all services provided under the terms of this Agreement whether those services are rendered by subcontractors or non-contracted providers and shall indemnify and hold harmless DSHS from any claims related to the provision of these services.

8.3. **Required Provisions in Subcontracts**

8.3.1. The Contractor shall ensure that all subcontracts are in writing and specify all duties, reports, and responsibilities delegated under this Agreement. Within 30 days of execution of a subcontract or amendment to a subcontract to perform any function under this Agreement the Contractor shall submit copies of the subcontract to MHD. When possible, copies are to be provided in word processing format on a Compact Disc.

8.3.2. Subcontracts must require subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the services to be performed under this Agreement.

8.3.3. Subcontracts must require subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.

8.3.4. Subcontracts must require subcontractors to participate in MHD offered training on the implementation of Evidence-based Practices and Promising Practices.

8.3.5. Subcontracts must require subcontractors to provide enrollees access to translated information and interpreter services as described in the Information Requirements section.

8.3.6. Subcontracts must require subcontractors to notify the Contractor in the event of a change of status of any required license or certification.

8.3.7. Subcontracts must require subcontractors to participate in training when requested by MHD.

8.3.8. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the MHD-CIS Data Dictionary.

8.3.9. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.

8.3.10. Subcontracts must require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by the Contractor or the Mental Health Division as part of a subcontractor review.

8.3.11. Subcontracts must require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to enrollees currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

8.3.12. Subcontracts must require that the subcontracted CMHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards, travel standards, and Access Standards.

8.3.13. Subcontracts must require that the subcontractor implement a Grievance process that complies with 42 CFR §438.400 or any successors and use the grievance template attached as Exhibit N, Grievance System Template.

8.3.14. Subcontracts must require the pursuit of all Third Party Revenue.

8.4. **Termination:** The termination of a subcontract that provides mental health services is considered a significant change in the provider network. The Contractor must notify MHD 30 days in advance of public written notice to enrollees before terminating any of its subcontracts with entities that provide direct service.

8.4.1. The Contractor must provide written notification within 15 days to enrollees receiving services from the subcontractor upon written notification of termination by either party.

8.4.2. If either party must terminate a subcontract in less than 30 days, the Contractor must notify MHD as soon as there is a determination to terminate the subcontract and in advance of public notice.

8.4.3. If a CMHA contract is terminated, the Contractor must submit a transition plan for enrollees and services in a format requested by MHD.

8.5. **Annual Review:** An annual formal review of subcontractors who perform the following activities must be performed by the Contractor. This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and MHD. The review must be based on the requirements set forth in this contract, the WAC and the RCW. The formal review must include at a minimum:

8.5.1. Quality clinical care;

8.5.2. Timely access;

8.5.3. Liability for Payment and the pursuit of third party revenue;

8.5.4. Quality Assessment and PIPs;

8.5.5. Intake Evaluations and Individual Service Plans; and

8.5.6. Practice Guidelines.

8.6. **Excluded Providers**

8.6.1. Debarment Certification. The Contractor, by signature to this Agreement certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement into any subcontracts entered into, resulting directly from the Contractor's duty to provide services under this Agreement.

8.6.2. The Contractor is required to ensure that the subcontractor neither employs any person nor contracts with any person or Community Mental Health Agency (CMHA) excluded from participation in federal health care programs under either 42 U.S.C. 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions;

8.6.3. Disclosure of 5% Ownership: The Contractor and any subcontractors must comply with 42-USC §1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or an employee, contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.

8.7. **Physician Incentive Plans**

8.7.1. The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not contract with any subcontractor operating such a plan.

8.8. **Provider Credentialing**

8.8.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs that are licensed and/or certified by the State.

9. ENROLLEE RIGHTS AND PROTECTIONS

9.1. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff takes those rights into account when furnishing services to enrollees.

9.2. The Contractor shall ensure mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:

9.2.1. The enrollee's mental health status;

9.2.2. Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner;

9.2.3. Any information the enrollee needs in order to decide among all relevant mental health treatment options;

9.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment);

9.2.5. The enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions;

9.2.6. The enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy;

9.2.7. The enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

9.2.8. The enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;

9.2.9. The enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the PIHP, CMHA or MHCP treats the enrollee;

9.2.10. Ensure that mental health professionals and MHCPs have an effective method of communication with enrollees who have sensory impairments; and

9.2.11. Provide or purchase age, linguistic and culturally competent community mental health services for enrollees for whom services are medically necessary and clinically appropriate.

9.3. Individual Service Plans must be developed in compliance with WAC 388-865-0425.

9.3.1. The Contractor shall ensure all enrollees participate in developing Individualized Service Plans, Advance Directives and Crisis Plans. This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings). At a minimum, treatment goals must include the words of the enrollee and documentation must be included in the clinical record describing how the enrollee sees his/her progress.

9.3.2. An individual peer support plan may be incorporated in the individual service plan.

9.4. The Contractor shall ensure enrollees are not held liable for any of the following:

9.4.1. Covered mental health services provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted;

9.4.2. Covered mental health services, including those purchased on behalf of the enrollee;

9.4.3. Covered mental health services which the State does not pay the Contractor;

9.4.4. Covered services provided to the enrollee, for which the State or the Contractor does not pay the MHCP or CMHA that furnishes the services under a contractual, referral, or other arrangement; or

9.4.5. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

9.5. **Ombuds**

9.5.1.1. The Contractor shall provide a mental health ombuds as described in WAC 388-865-0250 and RCW 71.24 as amended by Laws of 2005, ch. 504 (E2SSB 5763). The mental health ombuds cannot be employed or otherwise controlled by the Contractor.

9.6. **Advance Directives**

9.6.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects enrollees' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32 and the requirements of 42 CFR §422.128, Subpart I of part 489, and 42 CFR §438.6 as they pertain to psychiatric care. If State law changes, MHD will send notice to the Contractor who must then ensure the provision of notice to enrollees within 90 days of the change.

9.6.2. The Contractor shall inform enrollees that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with MHD by contacting the Quality Improvement and Assurance section at 1-888-713-6010.

9.7. **Choice of MHCP**

9.7.1. The Contractor shall ensure each enrollee is able to choose a participating MHCP in accordance with WAC 388-865-0345. If the enrollee does not make a choice, the Contractor or its designee must assign an MHCP no later than 14 working days following the request for mental health services. The enrollee may change MHCPs during the first 30 days of enrollment and once during a twelve-month period for any reason. Any additional change of an MHCP requested by an enrollee during a twelve-month period may be approved at the Contractor's discretion, provided that justification for the change is documented.

10. **CARE MANAGEMENT PROGRAM**

Care management pertains to a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions shall not be delegated to a network CMHA. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.

10.1. **Utilization Management Program**

10.1.1. The Contractor shall have a psychiatric medical director (consultant or staff) and sufficient care managers to carry out essential care management functions including:

10.1.1.1. A process for enrollees to access an intake evaluation and a process for referral to crisis intervention services. The Contractor must verify eligibility for Title XIX prior to the provision of services to an enrollee;

10.1.1.2. A utilization review of requested services against medical necessity criteria, authorization of necessary care, and administration of denials and appeals including access to expedited appeals;

10.1.1.3. Review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to evidenced based practice guidelines, discharge planning guidelines, and

community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies;

10.1.1.4. Monitoring for over-utilization and under-utilization of services and ensure that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee; and

10.1.1.5. Maintaining written policies and procedures for determining what constitutes medically necessary mental health services within the Contractor's service area. The policies and procedures must demonstrate:

10.1.1.5.1. Consistent application of review criteria for authorization decisions;

10.1.1.5.2. Consistent application of medical necessity criteria and the Access to Care Standards; and

10.1.1.5.3. Consultation with providers, when appropriate.

10.1.2. The Contractor shall participate as requested by MHD in the statewide analysis being conducted by the Performance Data Group of outpatient and inpatient hospital utilization rates for enrollees who are African American and Native American. The analysis will include, but is not limited to, factors that contribute directly and indirectly to utilization rates of these populations.

10.1.3. The Contractor shall maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or enrollees needing mental health services shift within the service area.

10.1.4. The Contractor shall monitor and adjust to situations in which there is:

10.1.4.1. Unanticipated need for MHCPs with particular types of experience; or

10.1.4.2. Unanticipated limitation of the availability of such MHCPs including identifying the numbers of MHCPs who are not accepting new enrollees.

10.2. **Resource Management:**

10.2.1. The Contractor must have a Resource Management plan that incorporates coordination and authorization of outpatient mental health services administered pursuant to an individual service plan.

10.2.2. The Contractor must ensure that the Access to Care Standards are incorporated into the Contractor's Level of Care Guidelines as the eligibility criteria for initial authorization of outpatient mental health services. In addition to the Access to Care Standards, the Contractor's Level of Care Guidelines must also include: criteria for use in determining continued or

re-authorization following the exhaustion of previously authorized benefits by the enrollee; and criteria for use in determining when an enrollee shall be discharged from outpatient community mental health services.

10.2.3. The Contractor must ensure that eligibility criteria for initial authorization of outpatient mental health services are consistent with the Access to Care Standards. From the time mental health services are authorized, the Contractor is responsible for providing uninterrupted access to a range of activities identified in the Medicaid State Plan to promote resiliency and recovery.

10.2.4. The Contractor's care management system must include a review of the Individual Service Plan to ensure the requirements of WAC 388-865-0425 are being met and that:

10.2.4.1. The enrollee's identified needs are being addressed;

10.2.4.2. The enrollee, and those he/she identifies as family when appropriate, are participating in the in the treatment planning; and

10.2.4.3. Input from other health, education, social service, and justice agencies is included, as appropriate and consistent with privacy requirements.

10.2.5. The Contractor must have review criteria for use in determining continued benefits or re-authorization following the exhaustion of previously authorized benefits by the enrollee. The review criteria must include:

10.2.5.1. An evaluation of the progress achieved and the effectiveness of each service modality provided during the benefit period;

10.2.5.2. An evaluation of the progress the enrollee made towards recovery or resiliency;

10.2.5.3. An identification of unmet goals in the individual service plan including those identified by the enrollee; and

10.2.5.4. A method for determining if an enrollee has met discharge criteria.

10.2.6. The Contractor shall maintain written policies and procedures, and be able to demonstrate, upon request, the consistent application of the Level of Care Guidelines within the Contractor's service area.

10.2.7. The Contractor must provide a written Notice of Action, in accordance with 42 CFR §438.404, when there is a denial, reduction, termination or suspension based on the PIHP Level of Care Guidelines.

10.2.8. The Contractor must have Care Managers available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve hours of the initial request.

10.2.8.1. If the authorization is denied, a Notice of Action must be provided to the enrollee.

10.2.8.2. Denials for certification of a psychiatric inpatient stay are reviewed by a psychiatrist. This must occur within three days of the initial denial.

10.2.9. If the Contractor denies payment of any portion of a psychiatric inpatient stay for enrollees and the inpatient facility appeals, the Contractor must respond to the appeal within 14 calendar days. The inpatient facility may appeal the Contractor's decision(s) to MHD after all reasonable effort is made to resolve the dispute between the Contractor and the inpatient facility.

10.2.10. Adherence to the requirements set forth Community Hospitalization Authorization Procedures (CHAP) available on the MHD Intranet or upon request.

10.2.11. The Contractor shall ensure that community psychiatric inpatient services are continued through an enrollee's discharge should a community hospital become insolvent, including any requirement for transfer.

11. MANAGEMENT INFORMATION SYSTEM – Think about a data collection process for inpatient if a private entity is doing direct contracting for community hospital.

11.1. Data Submission and Error Correction

11.1.1. The Contractor shall provide the MHD with all data described in the data dictionary for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference.

11.1.2. The Contractor shall submit encounters within 60 days of the close of each calendar month in which the encounters occurred.

11.1.3. The Contractor shall submit all other required data about enrollees to the MHD within 60 days of collection or receipt from subcontracted providers.

11.1.4. Upon receipt of data submitted to the MHD, the MHD will generate an error report. The Contractor shall have in place documented policies and procedures that assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the MHD error report was produced. All transactions will be final 180 days after the close of the submission month.

11.1.5. The Contractor shall have in place documented requirements to assure that data submitted by subcontractors and rejected due to errors is corrected and resubmitted within 30 calendar days of when the PIHP error report was produced.

11.1.6. The Contractor shall attend meetings and respond to inquires to assist in MHD decisions about changes to data collection and information systems to

meet the terms of this contract. This may include requests to add, delete or change data elements that may include projected cost analysis.

11.1.6.1. The Contractor shall implement changes made to the MHD data dictionary within 120 days from the date of published changes.

11.1.7. The Contractor shall ensure that, for requested information not covered by the data dictionary, data is provided in a timeframe developed with the MHD at the time of the request that will allow for a timely response to inquiries from CMS, the legislature, the MHD, and other parties.

11.1.8. The Contractor shall be liable for any costs associated with additional data processing once transactions are final. Except when corrections are requested in writing by the MHD director, an office chief or their designee, the Contractor will not be held liable for cost associated with making the changes.

11.2. Business Continuity and Disaster Recovery

11.2.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by the MHD. This must include the use of the Inter-Governmental Network (IGN), ISSD-approved secured Virtual Private Network (VPN) or other ISSD- approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on MHD approval. Documentation of the system to be used and its capabilities must be submitted to the MHD for approval.

11.2.2. The Contractor shall provide a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be submitted to the MHD for approval.

11.2.3. The Contractor will require all subcontractors to provide a business continuity and disaster recovery plan that insures timely reinstitution of the subcontractor's consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be provided to the MHD for approval.

11.2.4. The documentation required in this section must be submitted to the MHD within 60 days of the execution of this agreement.

11.3. Information System Security and Protection of Confidential Information

11.3.1. The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq. and 45 CFR parts 160, 162 and 164.

11.3.2. The Contractor shall maintain a statement on file for each individual service provider and contractor staff who has access to the Contractor's mental

health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality. (WAC 388-865-0275)

11.3.3. The Contractor shall take appropriate action if a subcontractor or Contractor employee willfully releases confidential information. (WAC 388-865-0275)

11.4. **Subcontractor Data Quality Verification**

11.4.1. The Contractor shall maintain and either provide to subcontractors, or require subcontractors to also maintain, a health information system that complies with the requirements of 42 CFR §438.242 and provides the information necessary to meet the Contractor's obligations under this agreement. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. Mechanisms shall include the following:

11.4.1.1. Data received from providers is accurate and complete by:

11.4.1.1.1. Verifying the accuracy and timeliness of reported data; and

11.4.1.1.2. Screening the data for completeness, logic and consistency of the data received from subcontractors.

11.4.1.2. The Contractor shall conduct encounter validation checks for all subcontractors that submit encounters to the Contractor, using the following method:

11.4.1.2.1. A review of 1% of all encounters or 250 encounters, whichever is less during the first 6 months of the Agreement period;

11.4.1.2.2. Compare the clinical record against the subcontractor's encounter data to determine agreement in type of service, date of service and service provider. This review must verify that the service reported actually occurred; and

11.4.1.2.3. Develop a report based on this information to be used by the PIHP in its data-monitoring activities. The report shall be submitted to the MHD 30 days prior to the end of this Agreement.

11.5. **Data Certification**

11.5.1. The Contractor shall provide certification of encounter data by one of the following: Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer. The certification will attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of data. Batches that contain data errors will not be considered certified until corrections for all errors are successfully received by the MHD.

11.5.2. The Contractor shall use only the MHD-supplied certification form and in the manner described in 42 CFR §§438.604 & 438.606.

11.5.3. The Contractor shall submit an electronic copy (e-mail is sufficient) of each certification on same the day that the certified data is submitted. The Contractor must send the original signed certification to the MHD Information Services Manager by mail as soon as possible.

11.5.4. The Contractor shall ensure that each certification contains an original signature of the signing authority.

11.5.4.1. If the signing authority is other than the CEO or CFO, the Contractor shall ensure a letter is submitted to the MHD containing an original signature by the CEO or CFO and indicates the name(s) of people delegated to sign. MHD must be notified by similar letter when delegation changes.

12. GRIEVANCE SYSTEM

12.1. General Requirements

12.1.1. The Contractor shall have in place a system for enrollees that includes a grievance process, an appeal process, and access to the State's administrative hearing system.

12.1.2. The Contractor's grievance system shall be consistently used throughout the Contractor's entire service area.

12.1.3. An enrollee may file a grievance or appeal or may have a representative who acts on his or her behalf in filing and pursuing grievances, appeals and administrative hearings.

12.1.4. If an enrollee or his/her representative wishes to appeal an action of the Contractor, he or she must request an appeal within within 20 days the enrollee's receipt of the Notice of Action. The enrollee must file a request within ten (10) calendar days of the receipt of notice of action to continue to receive previously authorized services during the appeal process (42 CFR §438.210(a)(1).

12.1.5. An enrollee or his/her representative must request a State administrative hearing within 20 days of receipt of the notice of disposition of an appeal by the Contractor if the disposition is not favorable to the enrollee.

12.2. Procedures

12.2.1. The enrollee or representative may file an appeal or grievance either orally or in writing.

12.2.2. A written, signed request for grievance must be submitted if an initial request for such has been made orally within 10 days.

12.2.3. A written, signed request for appeal must be submitted if an initial request for such has been made orally within seven (7) days.

12.2.4. The enrollee or representative may file a request for expedited appeal if the enrollee and/or representative believe that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning.

12.2.5. The enrollee must be given reasonable assistance in pursuing an appeal, grievance or administrative hearing, including access to the Ombuds service and oral or manual interpreter services. Toll free numbers that have adequate TTY/TTD and interpreter capability are required.

12.3. **Notice of Action**

12.3.1. Notices of Action must be in writing and must meet the language and format requirements of 42 CFR §438.10 (c &d), including, but not limited to, ease of reading, written notice in easily understood primary language of the enrollee and timeliness of notice.

12.3.2. The notice must explain the following:

12.3.2.1. The action the Contractor or its agent has taken or intends to take;

12.3.2.2. The reasons for the action;

12.3.2.3. The enrollee's or the CMHA's (acting on behalf of the enrollee) right to file an appeal with the Contractor;

12.3.2.4. The enrollee's right to request an appeal; and

12.3.2.5. The procedures for exercising the rights specified in this section.

12.3.3. The Contractor or its agent must mail the notice within the following timeframes:

12.3.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten days before effective date of the action except if the criteria noted in 42 CFR §431.213 or §431.214 are met;

12.3.3.2. For denial of payment, at the time of any action affecting the payment; and

12.3.3.3. For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's mental health condition requires, and no longer than fourteen (14) days from request for service. Under certain circumstances, 14 additional days are possible.

12.3.4. Standard authorization decisions not reached in accordance with the timeframes established in Access Standards above constitute a denial and an adverse action that are subject to appeal.

12.4. **Content of Notice**

12.4.1. The Notice of Action must include:

12.4.1.1. A statement of what action the PIHP or its Contractor intends to take;

12.4.1.2. The reasons for the intended action;

12.4.1.3. An explanation of the enrollee's right to request an appeal or a State administrative hearing; and

12.4.1.4. Definitions of reduction, termination, suspension and denial.

12.5. **Handling of Grievances and Appeals**

12.5.1. General requirements. In handling grievance and appeals, each PIHP or agent must meet the following requirements:

12.5.1.1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability;

12.5.1.2. Acknowledge receipt of each grievance and appeal, received either orally or in writing within one working day. If notification is made orally, it must be followed-up in writing within five working days;

12.5.1.3. Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making;

12.5.1.4. Ensure that the individuals who make decisions on appeals regarding medical necessity, expedited resolution, or involving clinical issues are qualified mental health care professionals who have the appropriate clinical expertise; and

12.5.1.5. Ensure that no retaliation against enrollees who file a grievance or appeal occurs.

12.5.2. The process for appeals must:

12.5.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals and therefore establish the earliest possible filing date for the appeal. Oral inquiries must be confirmed in writing;

12.5.2.2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

12.5.2.3. Provide the enrollee opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process; and

12.5.2.4. Provide the enrollee with an expedited appeal process when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning.

12.6. **Resolution and Notification**

12.6.1. General Requirements for Resolution

12.6.1.1. The PIHP must resolve each grievance and appeal, and provide written notice, as expeditiously as the enrollee's mental health condition requires, and not more than thirty (30) days from statement of grievance; or forty-five (45) days from receipt of notice of appeal.

12.6.1.2. The PIHP may extend the prescribed timeframes for resolution by written agreement, if the enrollee or Community Mental Health Agency acting on the client's behalf requests the extension. The timeframes cannot exceed 90 days for a grievance or 45 days for appeals.

12.6.1.3. If the PIHP extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

12.6.1.4. For all appeals, the PIHP must provide written notice of disposition within prescribed timeframes for normal disposition or extension.

12.6.1.5. All levels of resolution and appeal must occur at the PIHP prior to filing for an administrative hearing.

12.6.1.6. For notice of expedited resolution the PIHP must also make reasonable effort to provide oral notice with written notice in three working days.

12.6.1.7. Following notice of disposition of appeal, the enrollee may request an Administrative Hearing, conducted by an independent State agency in accordance with WAC 388-02 and provisions of mental health services, per WAC 388-865.

12.6.1.8. If the enrollee elects to request an Administrative Hearing, the request must be filed within 20 days from date of notice of adverse ruling.

12.6.1.9. The Administrative Hearing process must be completed within ninety (90) days of the date the appeal was initially filed, excluding any time taken by the enrollee to file for an Administrative Hearing following receipt of the notice of disposition of appeal.

12.6.2. General Requirements for Notification

12.6.2.1. The written notice of the resolution must include the following:

12.6.2.1.1. The results of the resolution process and the date it was completed.

12.6.2.2. For appeals not resolved wholly in favor of the enrollees, the notice must include:

12.6.2.2.1. The right to request a State Administrative hearing, and how to do so;

12.6.2.2.2. The right to request to receive benefits while the hearing is pending;

12.6.2.2.3. How to make the request; and

12.6.2.2.4. Notice that the enrollee may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

12.7. **Continuation of Benefits**

12.7.1. The PIHP must continue the enrollee's benefits if:

12.7.1.1. The enrollee or the Community Mental Health Agency files the appeal timely;

12.7.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

12.7.1.3. The services were ordered by an authorized Community Mental Health Agency;

12.7.1.4. The original period covered by the original authorization has not expired; and

12.7.1.5. The enrollee requests extension of benefits.

12.7.2. If, at the enrollee's request, the PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

12.7.2.1. The enrollee withdraws the appeal;

12.7.2.2. Ten days pass after the PIHP mails notice of disposition of an appeal or grievance and the resolution is not in favor of the enrollee, unless the enrollee requests a State Administrative hearing; or

12.7.2.3. The enrollee requests an Administrative hearing and the decision is adverse to the enrollee.

12.7.2.4. Enrollees who request continuation of benefits must be notified that, if the final resolution of the appeal is adverse to the enrollee (upholds the PIHP's action) the PIHP may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal is pending.

12.7.3. Effectuation of Reversed Appeal Resolutions

12.7.3.1. If the PIHP or the State Administrative hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's mental health condition requires.

12.7.3.2. If the PIHP or the State Administrative hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PIHP must pay for those services.

12.7.4. Information to sub-contractors

12.7.4.1. The PIHP must provide information about the grievance system to all Community Mental Health Agencies and sub-contractors at the time they enter into a contract. A condition of the contract will be that all Community Mental Health Agencies and sub-contractors will abide by all appeals, grievances and administrative hearing decisions.

12.8. **Recordkeeping and Reporting Requirements**

12.8.1. PIHPs must maintain records of appeals, actions, grievances and administrative fair hearings and must review the information per the timelines listed below.

12.8.2. The Contractor must submit a report in a format provided by MHD that includes:

12.8.2.1. The number and nature of actions, administrative fair hearings, grievances and appeals;

12.8.2.2. The timeframes within which they were disposed of or resolved;

12.8.2.3. The nature of the decisions; and

12.8.2.4. A summary and analysis of the implications of the data, including what measures may be taken to address undesirable patterns.

12.8.2.5. The report periods are October to March and April to September. In the event that the contract term does not encompass a full report period the Contractor shall provide a report for the partial period. Reports are due 45 days following the end of a report period.

13. **BENEFITS**

13.1. All Medicaid enrollees requesting covered mental health services must be offered an intake evaluation as outlined in Access Standards. Authorization for further services must be based on medical necessity and the Access to Care Standards.

13.2. The Contractor shall provide, upon request, a second opinion from a mental health professional within the Service Area. If an additional mental health professional is not currently available within the network or the enrollee requests an out of network provider, the Contractor must provide or pay for a mental health professional outside the network, at no cost to the enrollee. The appointment for a second opinion must occur within 30 days of the request. The enrollee may request to postpone the second opinion to a date later than 30 days.

13.3. The Contractor shall ensure benefits are provided in accordance with the Contractors Level of Care Guidelines and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a required service) based solely upon the diagnosis, type of mental illness, or the enrollee's mental health condition.

13.4. The contractor shall notify enrollees of the services for which they are eligible and facilitate the following:

13.4.1. Notification of the enrollees of their determined level of care, how medical necessity was determined, and the services available within that level of care;

13.4.2. Enrollees' participation in decisions concerning his/her treatment options; and

13.4.3. Enrollees' choice of services and CMHA's.

13.5. The Contractor must provide the following mental health services for each enrollee when they are medically necessary:

13.5.1. Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

13.5.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

13.5.3. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

13.5.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid-enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and his/her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in his/her individual service plan. This service is provided by or under the supervision of a mental health professional.

13.5.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental

Health Division to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.
The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

13.5.6. Group Treatment Services: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid-enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

13.5.7. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the

individuals' needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

13.5.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her individual service plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a mental health professional.

13.5.9. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within

ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

13.5.10. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

13.5.11. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

13.5.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial

care, and medical services, and differs for other services in the terms of location and duration.

13.5.13. Peer Support: Services provided by peer counselors to Medicaid-enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

13.5.14. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

13.5.15. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for

discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

13.5.16. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

13.5.17. Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

13.5.18. Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one’s disease, the symptoms, precautions related to decompensation, understanding of the “triggers” of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments;

diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

13.5.19. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under the Medicaid Waiver is only available to those consumers who do not have this coverage under some other federal program

13.5.20. Supported Employment: A service for Medicaid enrollees who are currently neither receiving nor who are on a waiting list to receive federally-funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include;
  (a) Consumer strengths
  (b) Consumer abilities
  (c) Consumer preferences
  (d) Consumer's desired outcomes
- Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- Services are provided by or under the supervision of a mental health professional.

13.5.21. Mental Health Clubhouse - is a service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees

where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

- o Opportunities to work within the clubhouse, such work contributes to the operation and enhancement of the clubhouse community;
- o Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;
- o Assistance with employment opportunities: housing, transportation, education and benefits planning;
- o Operate at least ten hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and
- o Opportunities for socialization activities.

13.5.22. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

13.5.23. If the Contractor is unable to provide the services covered under this Agreement, the services must be purchased within 28 days for an enrollee with an identified need. The Contractor must continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.

13.6. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation and without prior authorization.

13.7. DSHS may petition CMS for a Medicaid State Plan Amendment during this contract period. If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of medically necessary mental health services no later than 30 days following CMS approval of the plan.

13.8. **Coordination of Care**

13.8.1. Psychiatric Inpatient Services:

13.8.1.1. The Contractor or its designee shall contact the inpatient unit within three working days for all enrollee admissions.

13.8.1.2. The Contractor or its designee shall provide to the inpatient unit any available information regarding the enrollee's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

13.8.1.3. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A CMHA must be designated prior to discharge for enrollees and their families seeking community support services.

13.8.1.4. The Contractor or its designee shall monitor enrollees discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 for enrollees who meet medical necessity and the Access to Care Standards. The Contractor or designee shall offer covered mental health services to enrollees to assist with compliance with LRA requirements.

13.8.1.5. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of enrollees on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for enrollees who meet medical necessity and the Access to Care Standards.

13.8.1.6. The Contractor shall ensure provision of services to enrollees on a Conditional Release under RCW 10.77.150 for enrollees who meet medically necessity and the Access to Care Standards.

13.8.1.7. The Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.

13.8.2. CLIP

13.8.2.1. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

13.9. **Early Periodic Screening Diagnosis and Treatment (EPSDT)**

13.9.1. Services under this section are provided to children and their families who are referred to the Contractor for mental health services by a physician under the EPSDT program.

13.9.2. The Contractor shall provide Resource Management Services for services offered through the community mental health system. The Contractor shall hire or designate at least one EPSDT Care Manager to provide RMS and act as gatekeeper.

13.9.3. An EPSDT Care Manager must:

13.9.3.1. Be a children's mental health professional or be supervised by a children's mental health professional;

13.9.3.2. Maintain a list on file of all EPSDT referrals received and made;

13.9.3.3. Coordinate initial evaluations; review services for medical necessity; develop and coordinate support services for the EPSDT referred individual and/or family; and coordinate, develop and staff the Individual Service Team; and

13.9.3.4. Facilitate communication between physicians and mental health clinicians and maintain an open referral process and communication between physical and mental health care.

13.9.4. The Contractor shall promote local community participation in the EPSDT program by providing training and consultation to early intervention services, local health, mental health, juvenile justice, education and child welfare staff regarding EPSDT services.

13.9.5. The Contractor shall ensure accessible services, resource development, data collection and maintenance of required program records.

13.9.6. The Contractor shall ensure that upon referral to mental health from a health care professional, a child mental health specialist conducts an intake evaluation of the child's mental health status within 10 working days from the date of referral. If circumstances occur that prevent the completion of the mental health intake evaluation within 10 days, the EPSDT Care Manager shall describe in the clinical record the problems encountered, the remedial actions to be taken, and a specific time-line for completion of the comprehensive assessment. The comprehensive assessment must include at a minimum:

13.9.6.1. a developmental, psycho-social and medical history of the child;

13.9.6.2. the child's current condition;

13.9.6.3. the child's academic/learning problems;

13.9.6.4. the family's needs; and,

13.9.6.5. a chemical dependency assessment, if appropriate

13.9.7. The Contractor shall give priority to referred EPSDT children for evaluation and services over Medicaid children who self-refer.

13.9.8. Mental health services to EPSDT children must be structured in ways that are culturally and age appropriate and involve the family.

13.9.9. Once the assessment is completed, the EPSDT Care Manager will determine whether Level I or Level II services should be authorized. The EPSDT Care Manager must collaborate with the child and the family and other agencies when determining whether Level I or II services appropriately meet the needs of the child/family. The EPSDT Care Manager must inform the family of the services authorized for the child but shall not include the label of Level I or Level II services when providing this information.

13.9.10. The EPSDT Care Manager shall authorize Level I services as described in the Access to Care Standards for children who have a minimal need for service.

13.9.10.1. If Level I services are authorized, the EPSDT Resource Manager will develop the Individual Service Plan (ISP) and make a referral for treatment services.

13.9.10.2. Level I services may be provided by other appropriate child-serving agencies, i.e., schools, youth service centers, etc., which provide a comparable service to the Community Mental Health Agency to meet the needs of the individual child and family. Some services may not be reimbursed by medical coupons but are still considered part of the overall service plan.

13.9.11. If an EPSDT child and family receive the maximum services allowed under Level I and there still appears to be a need for additional Level I services or multi-agency services, the EPSDT Care Manager must review the ITP. After review, the EPSDT Care Manager may either re-authorize Level I services for a brief period of time, or authorize Level II services and refer the child and family to Level II treatment services.

13.9.12. The EPSDT Care Manager shall authorize Level II services described in the Access to Care Standards for children who meet any of the following requirements:

13.9.12.1. are priority population children as defined in RCW 71.24;

13.9.12.2. are in need of intensive services;

13.9.12.3. are involved with more than one service system;

13.9.12.4. are Severely Emotionally Disturbed (SED);

13.9.12.5. are at risk of out-of-home placement, or

13.9.12.6. have a chronic and disabling medical condition.

13.9.13. Children served by two or more systems shall have Level II services authorized.

13.9.14. Level II services consist of longer term intensive community-based options, integrated across all service systems involved to meet the complex needs of an individual child and family. The services will also be individually tailored for the specific child and family to be served.

13.9.15. At least ten percent (10%) of children authorized for level two services will be referred to an Individual Service Team (IST) established for that specific child for further evaluation and development of a cross-system Comprehensive Service Plan (CSP).

13.9.15.1. The IST must include, as appropriate, cross-system professionals including, but not limited to, representatives from education, child welfare, mental health, drug and alcohol, developmental disabilities, and juvenile justice. The parent or guardian of the child may be included as appropriate. The child must be included if age 13 or older. Younger children may be included if the IST agrees.

13.9.15.2. The cross-system CSP must address the overall needs of the child and family, not just Medicaid reimbursable services, in all life areas including residential, family, social, and medical needs. The CSP must clearly identify which system is responsible for each piece of the care.

13.9.15.3. The EPSDT Care Manager shall review the cross-system CSP for mental health services. Other local agency administrators must review the cross-system CSP for their agencies' role and responsibilities in the CSP. After review, the EPSDT Resource Manager will authorize the CSP or return it to the IST for revision.

13.9.15.4. The EPSDT Care Manager shall ensure that the IST reviews the CSP at least semi-annually and reconfigures services as necessary.

13.9.16. The Contractor shall provide technical assistance/consultation and team-building training at the community level.

13.9.17. The Contractor is responsible for coordinating with community interagency councils, State agencies and divisions, as appropriate. If appropriate, the ITP or CSP may be tied in with other plans, such as an Individual Education Plan (IEP) or through special education programs of the federal IDEA law 99-457's Individual Family Service Plan (IFSP).

13.9.18. The Contractor is responsible for placing EPSDT issues on the agenda of the RSN Advisory Board and the RSN Governing Board when appropriate.

13.9.19. The Contractor shall provide MHD a report that contains the following:

13.9.19.1. Number of unduplicated children referred;

13.9.19.2. Level of service to which they are categorized;

13.9.19.3. Types of services required;

13.9.19.4. Utilization, and

13.9.20. Expenditures associated with each child.

13.10. **Allied System Coordination:**

13.10.1. The RSN shall develop a allied system coordination plan for each of the following programs:

13.10.1.1. Aging and Disability Services Administration (ADSA)

13.10.1.2. Chemical Dependency and Substance Abuse services

13.10.1.3. Children's Administration

13.10.1.4. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans

13.10.1.5. Criminal Justice (courts, jails, law enforcement, pubic defender, Department of Corrections)

13.10.1.6. Division of Vocational Rehabilitation

13.10.1.7. Juvenile Rehabilitation Administration

13.10.1.8. K-12 Education System

13.11. **Allied System Coordination Plan.** Each allied system coordination plan must contain the following:

13.11.1. Clarification of roles and responsibilities of the allied systems in serving multi-system consumers;

13.11.2. Processes for the sharing of information related to eligibility, access and authorization.

13.11.3. Identification of needed local resources, including initiatives to address those needs;

13.11.4. A process for facilitation of community reintegration from out-of-home placements (e.g. State hospitals, Children's Long- term Inpatient facilities,

Juvenile Rehabilitation Administration facilities, foster care, nursing homes, acute inpatient settings) for consumers of all ages;

13.11.5. A process or format to address disputes related to service or payment responsibility; and

13.11.6. A process to evaluate progress in cross-system coordination and integration of services.

14. **TRIBAL RELATIONSHIPS**

14.1. The Contractor must develop a plan in collaboration with each Tribal Authority in the Contractor's service area. The plan must be submitted to MHD within 90 days of the execution of this contract unless an extension has been granted by the MHD. The MHD will review and must approve the submitted plan. Provide documentation if the Tribal Authority declines to participate. The Contractor shall use the attached RSN/ Tribal Collaboration Planning Checklist as Exhibit B and the plan must contain:

14.1.1. Identification of Tribal Authority and relevant provider contacts for each Tribal Authority in the Contractor's service area;

14.1.2. A description of completed and planned collaboration activities with each Indian Nation;

14.1.3. A list of any culturally sensitive issues or culturally specific needs identified during consultation;

14.1.4. A description of any completed or planned Tribal Relations training to be provided to the RSN Administration and staff by the Contractor; and

14.1.5. Collaborative development of performance indicators which will be used to measure and evaluate the implementation and effectiveness of the RSN/ Tribal Collaboration plan.

14.2. The Contractor shall develop a written coordination plan which addresses delivery of medically necessary mental health services within the Contractor's service area that have a tribal affiliation. The contractor will have these agreements with entities named by the MHD at the time the contract is executed. The coordination plan must address the following:

14.2.1. The reduction of duplicative screening and evaluation processes and ongoing coordination of care.

14.2.2. Identification and process for the provision of culturally appropriate, sensitive, and relevant medically necessary mental health services for eligible Tribal MH clients needing services through the RSN.

14.2.3. Coordination of care with Tribes who's membership crosses multiple RSN boundaries.

15. **REMEDIAL ACTIONS**

15.1. MHD may initiate remedial action if it is determined that any of the following situations exist:

15.1.1. A problem exists that negatively impacts individuals receiving services;

15.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement;

15.1.3. The Contractor has failed to develop, produce, and/or deliver to MHD any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement;

15.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of mental health services; or

15.1.5. The Contractor has failed to implement corrective action required by the State and within MHD prescribed timeframes.

15.2. MHD may impose any of the following remedial actions:

15.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to MHD within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. MHD may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

15.2.1.1. Corrective action plans must include:

15.2.1.1.1. A brief description of the situation requiring corrective action;

15.2.1.1.2. The specific actions to be taken to remedy the situation;

15.2.1.1.3. A timetable for completion of the actions; and

15.2.1.1.4. Identification of individuals responsible for implementation of the plan.

15.2.1.2. Corrective action plans are subject to approval by MHD, which may:

15.2.1.2.1. Accept the plan as submitted;

15.2.1.2.2. Accept the plan with specified modifications;

15.2.1.2.3. Request a modified plan; or

15.2.1.2.4. Reject the plan.

15.2.2. Withhold up to five percent of the next monthly capitation payment and each monthly capitation payment thereafter until the corrective action has achieved resolution. MHD, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

15.2.3. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

15.2.4. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which MHD provides incentives.

15.2.5. Terminate for Default as described in the General Terms and Conditions.

16. GENERAL TERMS AND CONDITIONS

16.1. **Assignment.** The Contractor shall not assign this Agreement or Program Agreement to a third party without the prior written consent of DSHS.

16.2. **Amendment**. This Agreement may only be modified by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

16.3. **Billing Limitations.** Unless otherwise specified in this Agreement, DSHS shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

16.4. **Compliance with Applicable Law**. At all times during the term of this Contract, the Contractor shall comply with all applicable federal, State, and local laws and regulations, including but not limited to, nondiscrimination laws and regulations.

16.5. **Confidentiality.** In addition to any other provisions in this Agreement regarding confidentiality, the parties shall use Personal Information and other information gained by reason of this Agreement only for the purpose of this Agreement. DSHS and the Contractor shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information, without the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Information and other information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.

16.6. **Debarment Certification.** The Contractor, by signature to this Agreement certifies that the Contractor is not presently debarred, suspended, proposed for debarment,

declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement into any subcontracts entered into, resulting directly from the Contractor's duty to provide services under this Agreement.

16.7. **Entire Agreement.** This Agreement, including all documents attached to or incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.

16.8. **Governing Law and Venue.** This contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County. In the event that an action is properly brought in, or removed to, U.S. District Court, venue shall be in the Western District of Washington.

16.9. **Independent Contractor.** The parties intend that an independent contractor relationship will be created by this contract. The Contractor and his or her employees or agents performing under this contract are not employees or agents of the Department. The Contractor, his or her employees, or agents performing under this contract will not hold himself/herself out as, nor claim to be, an officer or employee of the Department by reason hereof, nor will the Contractor, his or her employees, or agent make any claim of right, privilege or benefit that would accrue to such employee.

16.10. **Inspection.** During the term of this Agreement, and for one (1) year following termination or expiration of this Agreement, the Contractor shall provide reasonable access to the Contractor's and subcontractor's place of business, Contractor records, and client records, to DSHS and to any authorized agent of the State of Washington or federal government in order to monitor, audit, and evaluate the Contractor's performance and compliance with applicable laws, regulations, and this Agreement.

16.11. **Order of Precedence.** In the event of any inconsistency or conflict between the General Terms and Conditions and the Special Terms and Conditions of this Agreement or any Program Agreement, the inconsistency or conflict shall be resolved by giving precedence to these General Terms and Conditions

16.12. **Severability.** If any term or condition of this Contract is held invalid by any court, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

16.13. **Survivability.** The terms and conditions contained in this Agreement which by their sense and context, are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Confidentiality, Disputes, Inspection, Maintenance of Records, Mutual Indemnification and Hold Harmless, Ownership of Material, Termination for Default, Termination Procedure, and Treatment of Assets Purchased by the RSN, and Treatment of Property.

16.14. **Termination Due to Change in Funding:** If the funds upon which DSHS relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, DSHS may terminate this Agreement by providing at least five (5) business days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

16.15. **Waiver.** Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the DSHS Chief Administrative Officer or designee has the authority to waive any term or condition of this Contract on behalf of DSHS.

17. SPECIAL TERMS AND CONDITIONS

17.1. **Advisory Board**: The Contractor shall maintain an advisory board that is broadly representative of the demographic character of the region which shall include, but not be limited to, representatives of consumers and families, and law enforcement. Composition and length of terms of board members may differ between regional support networks. Membership shall be comprised of at least 51% consumers or consumer family members as defined in WAC 388-865-0222. Composition of the advisory board and the length of terms must be submitted to MHD by within 90 days of the execution of the agreement for approval.

17.2. **Compliance with Applicable Law**. At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

17.2.1. Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations;

17.2.2. All applicable Office of Insurance Commissioner's (OIC) statutes and regulations;

17.2.3. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement;

17.2.4. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA;

17.2.5. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act;

17.2.6. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA);

17.2.7. Those specified in Title 18 RCW for professional licensing;

17.2.8. Reporting of abuse as required by RCW 26.44.030;

17.2.9. Industrial insurance coverage as required by Title 51 RCW; and

17.2.10. Any other requirements associated with the receipt of federal funds.

17.2.11. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or Centers for Medicare and Medicaid Services (CMS) policy guidance is hereby amended to conform to the provisions of State and federal law and regulations.

17.3. **Confidentiality of Personal Information**

17.3.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

17.3.1.1. Establishing eligibility;

17.3.1.2. Determining the amount of medical assistance;

17.3.1.3. Providing services for recipients;

17.3.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan;

17.3.1.5. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement; and

17.3.1.6. Improving quality.

17.3.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR §§ 160 -164).

17.4. **Contractor Certification Regarding Ethics.** By signing this Agreement, the Contractor, whether or not county-based, certifies that the Contractor is in compliance with the standards set forth in Chapter 42.23 RCW and shall comply with these standards throughout the term of this Agreement.

17.5. **Declaration That Individuals Served Under the Medicaid and Other Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.** Although DSHS and the Contractor mutually recognize that services under this Agreement will be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, and RCW 71.34, it is not the intention of either DSHS or the Contractor that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement.

17.6. **Disputes**. When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute.

17.6.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and DSHS Contact listed on page one (1) of this Agreement.

17.6.2. If the Contractor is not satisfied with the outcome, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the postmark of the notice from DSHS, to: Chief, Mental Health Services, Mental Health Division, P.O. Box 45320, Olympia, WA 98504-5320.

17.6.3. The Chief, Mental Health Services, may request additional information from the DSHS Contact and/or the Contractor. The Chief shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor.

17.6.4. When the Contractor disagrees with the written review decision of the Chief, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the MHD Director, in writing within ten (10) working days of the Contractor's receipt of the Chief's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all cost associated with mediation equally. The results of mediation shall not be binding on either party.

17.6.5. Both parties agree to make their best efforts to resolve disputes arising from this Agreement and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this Agreement.

17.7. **Duplicative Reports and Deliverables.** If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one report or deliverable that contains the information required by both Agreements.

17.8. **Fraud and Abuse.** Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable Federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The Contractor shall do the following to guard against Fraud and Abuse:

17.8.1. Create and maintain a mandatory compliance plan;

17.8.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

17.8.3. Designate a compliance officer and a compliance committee that is accountable to senior management;

17.8.4. Provide effective ongoing training and education for the compliance officer, staff of the PIHP, and selected staff of the CMHAs;

17.8.5. Facilitate effective communication between the compliance officer, the PIHP employees, and the Contractor's network of CMHAs;

17.8.6. Enforce standards through well-publicized disciplinary guidelines;

17.8.7. Conduct internal monitoring and auditing;

17.8.8. Respond promptly to detected offenses and develop corrective action initiatives; and

17.8.9. Report fraud and/or abuse information to MHD as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

17.9. **Information Requests**: The Contractor shall maintain information necessary to promptly respond to written requests by the MHD Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by MHD Director, an Office Chief or their designee.

17.10. **Insurance.** The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance. The Contractor shall pay for losses for which it is found liable. The Contractor shall provide a certificate of insurance at the time of renewal or at least annually.

17.11. **Indemnification and Hold Harmless**. The Contractor shall be responsible for and shall indemnify and hold DSHS harmless from all claims or damages resulting from negligent acts or omissions of the Contractor and any subcontractor.

17.12. **Lobby Activities Prohibited.** Federal Funds must not be used for Lobbying activities.

17.13. **Maintenance of Records**. During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

17.13.1. The Contractor shall maintain records sufficient to:

17.13.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211;

17.13.1.2. Document performance of all acts required by law, regulation, or this Agreement;

17.13.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance; and

17.13.1.4. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

17.13.2. The Contractor and its subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.

17.13.3. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.

17.13.4. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

17.14. **Overpayments**. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with OMB Circular A-87.

17.15. **Ownership of Material**. Material created by the Contractor and paid for by DSHS as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by the US Copyright Act, 17 USC, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement, but which is not created for or paid for by DSHS is owned by the Contractor; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS.

17.16. **Subcontracting**. The Contractor may subcontract services to be provided under this Agreement. The Contractor shall be responsible for the acts and omissions of any subcontractors.

17.16.1. The Contractor shall not subcontract with an individual provider or an entity with an individual who is an officer, director, agent, or manager, or who owns or has a controlling interest in the entity, and who has been convicted of crimes as specified in 42 USC §1320a.

17.17. **Subrecipients.** If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

17.17.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

17.17.2. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs;

17.17.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

17.17.4. Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its subcontractors who are subrecipients;

17.17.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

17.17.6. Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation; and

17.17.7. Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C, D, E, and G, and 28 C.F.R. Part 35 and 39. (See www.ojp.usdoj/gov/ocr for additional information and access to the aforementioned federal laws and regulations.)

17.18. **Single Audit Act Compliance.** If the Contractor is a subrecipient and expends $500,000 or more in federal awards from any and/or all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

17.18.1. Submit to the DSHS contact person, listed on the first page of this Agreement, the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor; For purposes of “subrecipient” status under the rules of OMB Circular A-133 205(i) Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis; and

17.18.2. Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, prepare a “Summary Schedule of Prior Audit Findings.”

17.19. **Termination for Convenience**. DSHS Contracts Administrator may terminate this Agreement, in whole or in part, when it is in the best interest of DSHS by giving the Contractor at least 90 calendar days’ written notification by certified mail. The Contractor may terminate this Agreement for convenience by giving DSHS at least 90 calendar days’ written notification receipt by certified mail addressed to: Mental Health Division, PO Box 45320, Olympia, Washington 98504-5320.

17.19.1. The effective date of the termination shall be the last day of the calendar month in which the ninetieth day occurs.

17.20. **Termination by DSHS for Default**

17.20.1. The CCS Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if DSHS has a reasonable basis to believe that the Contractor has:

17.20.1.1. Failed to meet or maintain any requirement for contracting with DSHS;

17.20.1.2. Failed to perform under any provision of this Agreement;

17.20.1.3. Performed any of the Contractor's obligations under this Agreement in a manner that comprised the health or safety of any individual with whom the Contractor had contact;

17.20.1.4. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement, including those pertaining to health and safety; or

17.20.1.5. Otherwise breached any provision or condition of this Agreement.

17.20.2. Before the CCS Contracts Administrator may terminate this Agreement for default, DSHS shall provide the Contractor with written notice of the Contractor's noncompliance with this Agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the CCS Contracts Administrator may then terminate this Agreement. The CCS Contracts Administrator, however, may terminate this Agreement for default without such written notice and without opportunity for correction if DSHS has a reasonable basis to believe that an individual's health or safety is in jeopardy or if the Contractor has violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement.

17.21. **Termination Procedure**. The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

17.21.1. The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of individuals, distribution of property, and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Agreement, rendered prior to the effective date of termination. The Contractor shall assist in the orderly transfer/transition of the individuals served under this Agreement. The Contractor shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

17.21.2. The Contractor shall immediately deliver to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement all DSHS assets (property) in the Contractor's possession, including any material created under this Agreement. The Contractor grants DSHS the right to enter upon the Contractor's premises for the sole purpose of recovering any DSHS property that the Contractor fails to return within ten (10) working days of termination of this Agreement. Upon failure to return DSHS property within ten (10) working days of termination of this Agreement, the Contractor shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. The Contractor shall protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

17.21.3. DSHS shall be liable for and shall pay for only those services authorized and provided through the date of termination. DSHS may pay an amount agreed by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

17.21.4. If the CCS Contracts Administrator terminates this Agreement for default, DSHS may withhold a sum from the final payment to the Contractor that DSHS determines necessary to protect DSHS against loss or additional liability. DSHS shall be entitled to all remedies available at law, in equity, or under this Agreement, including consequential damages, incidental damages, legal fees, and costs. If it is later determined that the Contractor was not in default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement, including consequential damages, incidental damages, legal fees, and costs.

17.21.5. The DSHS Secretary may direct assignment of the Contractor's rights to and interest in any subcontract or orders placed to DSHS. DSHS may terminate any subcontract or orders and settle or pay any or all claims arising out of the termination of such orders and subcontracts.

17.22. **Treatment of Individual's Property**. Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult individual receiving services from the Contractor under this Agreement has unrestricted access to the individual's personal property. The Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. The Contractor shall provide individuals under age eighteen (18) with reasonable access to their personal property that is appropriate to the individual's age, development, and needs. Upon termination of this Agreement, the Contractor shall immediately release to the individual and/or the individual's guardian or custodian all of the individual's personal property.

17.23. **Treatment of Property**. Title to all property purchased or furnished by DSHS for use by the Contractor during the term of this Agreement shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Agreement shall pass to and vest in DSHS. The Contractor shall protect, maintain, and insure all DSHS property in its

possession against loss or damage and shall return DSHS property to DSHS upon this Agreement's termination or expiration.

17.23.1. Except as provided in this Agreement, title to all property purchased or furnished by the Contractor is vested in the Contractor and DSHS waives all claim of ownership to such property.